Iowa Department of Public Health

Application for Authorization for Cannabidiol Registration Card

Section I – Patient Information: ***(Required)***

This section must be completed by the patient or the parent or custodial guardian if the patient is under age 18 or is age 18 or older, but unable to complete the form.

"Patient" means a person who is a permanent resident of the state of Iowa who suffers from intractable epilepsy and has received a recommendation from a neurologist for the medical use of cannabidiol pursuant to 2014 Iowa Acts, Senate File 2360.

"Permanent resident" means a natural person who physically resides in Iowa as the person's principal and primary residence.

Section II - Primary Caregiver Information: ***(Required for Patients under age 18, Optional for Patients 18 and older)*** Section II must be completed by patient's primary caregivers if the caregivers will be requesting a registration card.

"Primary Caregiver" means a person, at least eighteen years of age, who has been designated by a patient's neurologist or a person having custody of a patient, as being necessary to take responsibility for managing the well-being of the patient with respect to the medical use of cannabidiol pursuant to the provisions of 2014 Iowa Acts, Senate File 2360.

Section II includes space for application for up to three primary caregivers. If more than three caregivers will be applying, applicants should use ***Attachment A – Additional Caregiver Form***.

Section III - Neurologist Recommendation - Medical Cannabidiol Use for Intractable Epilepsy: ***(Required)*** Section III must be completed by the patient's neurologist.

"Neurologist" is defined as an allopathic or osteopathic physician board-certified in neurology in good standing and licensed under Iowa Code chapter 148.

After Section III has been completed by the patient's neurologist, the neurologist, or an authorized person in the neurologist's office or clinic, is required to send the entire completed application and required attachment(s) to:

Iowa Department of Public Health
c/o MCA Registration Card Program
Lucas State Office Building
321 E. 12th Street
Des Moines, IA 50319-0075

Approval Notice: The patient, if age 18 or older, the primary caregiver applicants(s), if applicable, and the recommending neurologist will be notified via mail of the application's status. If the application is approved by the Iowa Department of Public Health, the notice will include information on how to complete the card application process through the Iowa Department of Transportation.

The application must contain all requested information to be approved by the Iowa Department of Public Health. If the application is incomplete, a request for the missing information will be sent via mail to the patient, if age 18 or older, the patient's parent or custodial guardian.

Questions related to the application process may be directed to the Iowa Department of Public Health by calling 515-281-5616. All calls will be returned within 48 hours of receipt during regular office hours, Monday through Thursday, 8:00am – 5:30pm. Calls received on Fridays will be returned on the next regular business day the following week.

Application for Authorization for Cannabidiol Registration Card

SECTION I. PATIENT INFORMATION *(If completing the form by hand, please print.)*

A. **Patient Name**: _____
(first) (middle) (last)

B. **Permanent Iowa Address**: _____
(street and number)

_____
(city) (state) (zip code)

A patient must be a permanent resident who physically resides in Iowa as the person's principal and primary residence. Identify which of the following is enclosed with the application to show residency of the patient. Attach a copy of the item marked below to the application.

(Check which is applicable)

- ☐ A valid Iowa driver's license,
- ☐ A valid Iowa nonoperator's identification card,
- ☐ A valid Iowa voter registration card,
- ☐ A current Iowa vehicle registration certificate,
- ☐ A utility bill,
- ☐ A statement from a financial institution,
- ☐ A residential lease agreement,
- ☐ A check or pay stub from an employer,
- ☐ A child's school or child care enrollment documents,
- ☐ Valid documentation establishing a filing of homestead or military tax exemption on property located in Iowa, or
- ☐ Other valid documentation as deemed acceptable by the department to establish residency.

C. **Date of Birth**: __ __ / __ __ / __ __ __ __ **Age**: __ __ or __ __
(month) (day) (year) (years) (months, *if under 1 year of age*)

D. **Sex:** ☐ Male ☐ Female

E. **Telephone Number**: (__ __ __) __ __ __ - __ __ __ __

F. **Valid Photo Identification**:

(Check which is applicable)

- ☐ For a patient age 18 and older, a copy of the Patient's valid photo identification is attached.
- ☐ For a patient under age 18, a copy of the valid photo identification for each Primary Caregiver applicant is attached.

Patient Name: _____

G. **Treating Neurologist**

Neurologist Name: _____
(first) (last)

Neurologist Practice Name: _____

Neurologist Practice Address: _____
(street and number)

_____
(city) (state) (zip code)

Neurology Practice Telephone Number: (__ __ __) __ __ __ - __ __ __ __

APPLICANT PATIENT CERTIFICATION

I certify that all information provided by me on this application is true and correct. I understand that providing false or misleading information may result in the denial or cancellation of my Cannabidiol Registration Card and that the law provides severe penalties (fine and/or imprisonment) for the willful submission of known false information. **I understand that I am required to know and comply with the provisions of the Medical Cannabidiol Act and the administrative rules which implement this Act. I understand this application does not, by itself, provide authorization for the Cannabidiol Registration Card.**

Signature of patient, if age 18 or older: _____

Date: __ __/ __ __/ __ __ __ __

Signature of parent or legal guardian, if patient is under age 18: _____

Printed name of parent or legal guardian: _____

Date: __ __/ __ __/ __ __ __ __

Section II – PRIMARY CAREGIVER INFORMATION begins on the next page.

Application for Authorization for Cannabidiol Registration Card

SECTION II. PRIMARY CAREGIVER INFORMATION – *(Required for Patients under age 18, Optional for Patients 18 and older) (If completing the form by hand, please print.)*

Patient Name: _____

A. **Primary Caregiver** *(Required for Patients under Age 18)*

Name: _____
(first) (middle) (last)

Address: _____
(street and number)

_____
(city) (state) (zip code)

Date of Birth: __ __/ __ __/ __ __ __ __ **Sex:** ☐ Male ☐ Female
(month) (day) (year)

Telephone Number: (__ __ __) __ __ __ - __ __ __ __

B. **Valid Photo Identification**: Attach a copy of the Primary Caregiver's valid photo identification.

APPLICANT - PRIMARY CAREGIVER - CERTIFICATION

I have been designated by the patient's neurologist or by a person having custody of the patient as being necessary to manage the well-being of the patient with respect to the medical use of cannabidiol pursuant to Iowa Code chapter 124D, and I am willing and able to serve in this capacity. I certify that the foregoing statements and all information provided by me on this application are true and correct. I understand that providing false or misleading information may result in the denial or cancellation of my Cannabidiol Registration Card and that the law provides severe penalties (fine and/or imprisonment) for the willful submission of known false information. **I understand I am required to know and comply with provisions of the Medical Cannabidiol Act and the administrative rules which implement this Act. I understand this application does not, by itself, provide authorization for the Cannabidiol Registration Card.**

Signature: _____ Date: __ __/ __ __/ __ __ __ __

Application for Authorization for Cannabidiol Registration Card

SECTION II. PRIMARY CAREGIVER INFORMATION *(If completing the form by hand, please print.)*

Patient Name: _____

A. **Primary Caregiver** *(optional)*

Name: _____
(first) (middle) (last)

Address: _____
(street and number)

_____
(city) (state) (zip code)

Date of Birth: __ __/ __ __/ __ __ __ __ **Sex:** ☐ Male ☐ Female
(month) (day) (year)

Telephone Number: (__ __ __) __ __ __ - __ __ __ __

B. **Valid Photo Identification**: Attach a copy of Primary Caregiver's valid photo identification.

APPLICANT - PRIMARY CAREGIVER - CERTIFICATION

I have been designated by the patient's neurologist or by a person having custody of the patient as being necessary to manage the well-being of the patient with respect to the medical use of cannabidiol pursuant to Iowa Code chapter 124D, and I am willing and able to serve in this capacity. I certify that the foregoing statements and all information provided by me on this application are true and correct. I understand that providing false or misleading information may result in the denial or cancellation of my Cannabidiol Registration Card and that the law provides severe penalties (fine and/or imprisonment) for the willful submission of known false information. **I understand I am required to know and comply with provisions of the Medical Cannabidiol Act and the administrative rules which implement this Act. I understand this application does not, by itself, provide authorization for the Cannabidiol Registration Card.**

Signature: _____ Date: __ __/ __ __/ __ __ __ __

Application for Authorization for Cannabidiol Registration Card

SECTION II. PRIMARY CAREGIVER INFORMATION *(If completing the form by hand, please print.)*

Patient Name: _____

A. **Primary Caregiver** *(optional)*

Name: _____
(first) (middle) (last)

Address: _____
(street and number)

_____
(city) (state) (zip code)

Date of Birth: __ __/ __ __/ __ __ __ __ **Sex:** ☐ Male ☐ Female
(month) (day) (year)

Telephone Number: (__ __ __) __ __ __ - __ __ __ __

B. **Valid Photo Identification**: Attach a copy of the Primary Caregiver's valid photo identification.

APPLICANT – PRIMARY CAREGIVER - CERTIFICATION

I have been designated by the patient's neurologist or by a person having custody of the patient as being necessary to manage the well-being of the patient with respect to the medical use of cannabidiol pursuant to Iowa Code chapter 124D, and I am willing and able to serve in this capacity. I certify that the foregoing statements and all information provided by me on this application are true and correct. I understand that providing false or misleading information may result in the denial or cancellation of my Cannabidiol Registration Card and that the law provides severe penalties (fine and/or imprisonment) for the willful submission of known false information. **I understand I am required to know and comply with provisions of the Medical Cannabidiol Act and the administrative rules which implement this Act. I understand this application does not, by itself, provide authorization for the Cannabidiol Registration Card.**

Signature : _____ Date: __ __/ __ __/ __ __ __ __

Section III – NEUROLOGIST RECOMMENDATION begins on the next page.

Application for Authorization for Cannabidiol Registration Card

Patient Name: _____

SECTION III. NEUROLOGIST RECOMMENDATION - MEDICAL CANNABIDIOL USE FOR INTRACTABLE EPILEPSY – This section must be completed by the patient's neurologist. *(If completing the form by hand, please print.)*

The above signed individuals – Patient and/or Primary Care Giver(s) (Sections I and II) – request a written recommendation from the neurologist listed in *Section I, F. Treating Neurologist* for the patient's medical use of cannabidiol to treat or alleviate symptoms of intractable epilepsy.

A. **Neurologist Certifications regarding treatment provided to the Patient listed in Section I**.
(The neurologist must initial all that apply. All items must be marked as applicable by the neurologist in order for the registration card application to be approved.)

Initials

_____ I have examined and treated the patient (as listed in Section 1) for intractable epilepsy.
(print)(_____)
(patient first name) (patient last name)

_____ I, or another licensed neurologist, have treated the patient for intractable epilepsy for at least six months.

_____ I have tried alternative treatment options that have not alleviated the patient's symptoms.

_____ I have determined the risks of recommending the medical use of cannabidiol are reasonable in light of the potential benefit for the patient.

_____ I will maintain a patient treatment plan and shall recommend in the treatment plan only oral or transdermal administration of cannabidiol.

_____ I agree to be available to provide follow-up care and treatment to the patient, including but not limited to patient examinations, to determine the efficacy of the medical use of cannabidiol to treat or alleviate the patient's intractable epilepsy.

_____ I agree to maintain a record-keeping system for this patient for whom I have recommended the medical use of cannabidiol to treat or alleviate symptoms of intractable epilepsy.

_____ I agree to participate in a periodic survey that will be conducted by the Iowa Department of Public Health on the implementation of the medical cannabidiol act. The survey will adhere to the federal Health Insurance Portability and Accountability Act of 1996.

B. Neurologist

Name: _____
(first) (last) (credentials)

Practice Name: _____

Practice Address: _____
(street and number)

_____
(city) (state) (zip code)

Practice Telephone Number: (__ __ __) __ __ __ - __ __ __ __

Iowa medical license number: _____

Patient Name: _____

NEUROLOGIST RECOMMENDATION

With my signature below, and with the certifications marked above in *Section III. A*, I recommend the use of cannabidiol for the treatment of intractable epilepsy for the patient listed in *Section I*.

CAREGIVER DESIGNATION

I designate the following individual(s) in the role of primary caregiver as being necessary to take responsibility for managing the well-being of the patient with respect to the medical use of cannabidiol pursuant to the provisions of Iowa Code Chapter 124D

(Check all that apply)

- ☐ Primary Caregiver(s) – as noted in Section II of this application.
- ☐ Additional Primary Caregivers – as noted on attached pages of *Attachment A* of this application.

NEUROLOGIST CERTIFICATION

I certify that the foregoing statements and all information provided by me on this application are true and correct. I understand the law provides severe penalties (fine and/or imprisonment) for the willful submission of known false information. **I understand this application does not, by itself, provide authorization for the Cannabidiol Registration Card for the above named patient and/or caregiver(s).**

Signature: _____ Date: __ __/ __ __/ __ __ __ __

Please submit completed application, copy of the patient residency documentation, and copies of patient/primary caregiver state-issued driver's license or non-driver identification card to:

Iowa Department of Public Health
c/o MCA Registration Card Program
Lucas State Office Building
321 E. 12th Street
Des Moines, IA 50319-0075